DENTAL HEALTH

Indian Health Service Clinical Services	FY 1999 Enacted	FY 2000 Final Appropriation	FY 2001 Estimate	Increase or Decrease
Dental Health				
A. Budget Authority	$71,400,000	$80,062,000	$88,258,000	+$8,196,000
B. FTE	763	769	787	+18
C. Total Patients Treated	300,000	319,000	327,000	+8,000
D. Total Services Provided	2,400,000	2,458,000	2,485,000	+27,000

PURPOSE AND METHOD OF OPERATION

Program Mission and Responsibilities

The IHS Dental Program is committed to raising the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services at the community and clinic level. Despite a history of documented improvements in oral health status, the oral health of Indian people still lags well behind that of the overall population and this disparity may be increasing. For the past two years oral health problems have been identified by consumers participating in budget formulation activities among the top priorities for funding enhancement. As a result, oral health has been identified as one of the IHS Director's initiatives for FY 2001, and this budget request addresses the critical issues relative assuring access to dental services and restoring the dental public health infrastructure that underpins this access.

Between the early 1970s and the early 1990s, a period of overall dental program expansion, the IHS Dental Program made significant strides in improving the oral health of the AI/AN population. Results of the IHS-wide Oral Health Status and Treatment Needs Survey of over 25,000 dental patients completed in 1991 revealed several important findings. When compared with results from earlier monitoring surveys, a general decline in tooth decay among children and adults was detected. This encouraging trend can be attributed mainly to the extensive commitment that the IHS and local communities have made to water fluoridation during the past decade and the expanded use of dental sealant. However, AI/ANs continue to have substantially higher rates of dental caries and periodontal disease than the U.S. population at large, and since the early 1990s have had reduced access to dental services.

In addition to the very large backlog of needed dental care, two problems of particular concern are the extremely high prevalence of baby bottle

tooth decay among preschool age children and the prevalence and severity of periodontal disease and subsequent tooth loss among adult diabetics. The survey data better define the magnitude of these and other oral health problems and will guide resource planning at the local, regional and national program levels. A follow-up oral health survey is in process for FY 1999 to determine the current oral health status and continued or emerging problems that must be addressed. Preliminary results of this survey should be available by the end of FY 1999.

The IHS has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so the basic services may be provided to more persons. Within the Schedule of Services, a service priority hierarchy used by the Dental Program, over 90 percent of services provided are basic and emergency care. Estimates of treatment needs remain high; however, a continuing emphasis on community health promotion/disease prevention is essential to long-term improvement in the oral health of AI/ANs.

In 1992, the IHS added a full-time national coordinator for dental health promotion/disease prevention to provide technical assistance to IHS and tribal programs. Because of the significant loss of support of dental health promotion/disease prevention available at the Area level, the national coordinator has attempted to develop alternative networks including local I/T/U dental staff to carry on essential dental health promotion and disease prevention activities. Despite these efforts, prevention activities appear to have declined since the early 1990s.

Tribal programs continue to exert a growing influence in the management of oral health programs. The number of tribally managed programs continues to grow steadily. Staff employed by or providing care in tribal programs produce over a third of the total direct dental services. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. To meet this need, tribal programs were well represented in the IHS 1991 Oral Health Survey of Indian patients and are participating in the 1999 survey. Data gathered by these surveys provides tribes information from which to make rational decisions regarding their dental programs.

Tribal programs also participate in the IHS Dental Quality Assurance Program in which clinical care, program management and community activities are appraised. In general, tribal programs meet standards for clinical care. When deficiencies are found, tribal employees are encouraged to participate in IHS continuing education courses or to pursue local training to improve their programs. The tribal program role in community health promotion/disease prevention, need for efficient use of available resources, and the value of timely and accurate services data are themes that continue to be stressed during consultation.

Best Practices/Industry Benchmarks

The IHS Dental Program has a long and distinguished history of serving as a benchmark of dental public health excellence. Beginning in the 1960s, the IHS Dental Program was a pioneer in developing dental resource planning methods, and, in the early 1970’s, published some of the first and most

compelling findings regarding the efficiency and effectiveness of using expanded duty dental assistants in the provision of dental restorations. Later in the 1970s, the IHS published what still remains as one of the most comprehensive and recognized approaches to quality assurance for dental care. In the 1980s and 1990s, the IHS Dental Program was recognized by winning three U.S. Public Health Service J.D. Lane research competitions for community based research/education projects as well as three American Dental Association awards for health promotion/disease prevention. The program's Baby Bottle Tooth Decay Prevention Project, which won two of these awards, has been cited internationally as a model of community empowerment and program effectiveness. As part of these activities the IHS Dental Program collaborated with the World Health Organization, the Centers for Disease Control, the National Institutes of Health, the Head Start Bureau, and several acclaimed universities.

But, undoubtedly, the ultimate benchmark of success for the public health organizations is what it accomplishes in term of positive outcomes for the people it serves. Based on analyses comparing findings from the most recent (1991) oral health survey completed in 1994, the results show:

A **42 percent increase** in the number of children 5-19 years with no decay.

A **35 percent decrease** in the number of children 5-19 years with high decay rates (7 or more cavities).

An **800 percent increase** in the number of protective dental sealant placed in children's molar teeth.

A **17 percent increase** in the number of adults 35-44 years with 20 or more teeth remaining; a **29 percent increase** for those 45-54 years; and a **40 percent increase** for those 55 years and older.

In addition, the Baby Bottle Tooth Decay Prevention project documented an overall reduction in the prevalence of the condition of 32 percent over the five years of the study across all 12 sites with the largest site achieving a 78 percent reduction.

ACCOMPLISHMENTS

Since 1992, the IHS dental program has downsized the Area Offices and Headquarters dental public health professional staff from a total of 42 to 6 FTE (i.e., an 85 percent reduction) in an attempt to maximize resources available to support clinical care. Providing clinical care is the dental program's highest priority but in recent years both the percentage of the population seen annually and the total number of services provided have declined. However, the positions that were eliminated predominately supported core public health infrastructure and administrative functions. Thus, assuring the capability to support such functions as staff development, efficient and effective dental clinic and data management, and implementing effective oral health promotion/disease prevention activities with a reduced public health infrastructure has become a dental program priority. To achieve this goal, self-directed workgroups have been formed

composed of remaining dental staff from Headquarters and Area Offices, along with local dental program staff and are accomplishing many of the essential functions.

Specific accomplishments include:

- A workgroup has developed and is promoting clinical and community-based strategies to reduce the prevalence of early childhood decay. The strategies include: providing a dental screening or exam by age one by medical and dental providers; teaching parents to brush their child's teeth and looking for early lesions which can be reversed with fluorides; and educating families about the disease process, diet and the importance of various fluorides.

- To reduce the prevalence of the dental decay, and increase access to care, a work group has developed a medical model of care that addresses dental decay as an infectious disease. Some of the key concepts are the importance of diagnosis of caries, assessing the risk of disease and applying the most appropriate preventive regimens and recall frequencies based on the individual patients needs and demands.

- The IHS Dental Program has served an active role in the development of the Surgeon General's Report on Oral Health including drafting sections and reviewing the process and products of the effort.

- The IHS Dental Program began data collection in the periodic survey of American Indian and Alaska Native Oral Health Status and Treatment Needs in early FY 1999 with preliminary findings to be available in early FY 2000.

- The IHS, National Institutes of Dental and Craniofacial Research, and State University of New York at Buffalo continue to collaborate on the treatment of periodontal disease in persons with diabetes. The initial clinical trail conducted in the Phoenix Area demonstrated the effectiveness of a non-surgical treatment regimen. The project is currently being replicated in the Albuquerque Area. Three 5-year grants were awarded in FY 1998 to help IHS, tribal, and urban programs incorporate these procedures into their dental programs.

- The IHS and the Health Resources and Services Administration (HRSA) entered into an Intra-Agency Agreement to increase access to care for the unmet oral health needs of under served populations, including American Indian/Alaska Natives. An IHS officer is detailed part-time to HRSA to serve on the oral health initiative team.

PERFORMANCE MEASURES

The following performance indicators are included in the IHS FY 2001 Annual Performance Plan and are primarily dependent upon the activities funded within this budget line item for achievement. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN.

Indicator 11: Reduce dental decay rates by improving water fluoridation compliance in FY 2001 by 10 percent over FY 2000 levels for Areas participating in IHS/CDC Fluoridation Surveillance Demonstration Project.

Indicator 12: Improve oral health status by assuring that at least 25 percent of the AI/AN population obtain access to dental services during FY 2001.

Indicator 13: Reduce children's dental decay by assuring that the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth in FY 2001 is increased by 3 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1996	$62,783,000	861
1997	$65,517,000	861
1998	$65,517,000	818
1999	$71,400,000	763
2000	$80,062,000	769

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $88,258,000 and 787 FTE is an increase of $8,196,000 and 18 FTE over the FY 2000 Appropriation of $80,062,000 and 769 FTE. The increases are as follows:

Current Services – Built-in Increases: +4,147,000

The request of $4,147,000 for personnel related costs will partially fund the built-in increases associated with on-going operations. Included is the FY 2001 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2000 level of service to prevent any further decline in primary health services. The IHS patient population continues to receive less access to health care than the general U.S. population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$792,000 and 7 FTE

The request of $792,000 and 7 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	**Dollars**	**FTE**

Talihina, OK Hospital	$387,000	7 1/
Hopi, AZ Health Center	405,000	7
Total	$792,000	7

1/ Non-add - Tribally operated program.

Health Disparities - +$3,257,000 and 11 FTE

The requested $3,257,000 and 11 FTE increase for the IHS dental line item represents an incremental step in eliminating the disparity in oral health that AI/AN people experience by the year 2010 as prescribed in the President's Race Initiative.

It also supports the Secretary's FY 2001 Health Promotion/ Disease Prevention Initiative as a means to addressing this disparity with a focus of applying the emerging dental public health guidance from the developing Surgeon General's Report on Oral Health. The requested enhancements are focused on developing increased access to essential treatment and preventive services by developing and supporting the capability to deliver them in the most cost-effective manner possible and include:

- $1,000,000 will be used to hire approximately 11 FTE, which will extend basic dental services to about 5,000 additional people.
- $750,000 will be used to develop 3 new clinical and preventive services support centers, provide training and technical assistance to local I/T/U dental programs, improve clinical and preventive efficiency and effectiveness through improved clinic management and the implementation of new treatment technologies.
- $222,000 will be used for Advance General Practice Residency Training and Dental Specialist Training to develop greater treatment capability of dentists at local I/T/U dental clinics.
- $485,000 for dental data management including software upgrades to integrate "point and click" technology to increase data entry and performance monitoring efficiency and accuracy.
- $500,000 to expand the community water fluoridation support initiative to 3-5 new sites and thus increase access to an estimated 15,000-25,000 people to this effective public health intervention.
- $300,000 will be used for 3 additional diabetic periodontal disease treatment projects. These projects wil support the exportation of the diabetic periodontal disease treatment protocol developed with the National Institute of Dental and Craniofacial Research and State University of New York at Buffalo. These projects will increase access to an effective non-surgical alternative to the treatment of periodontal disease in diabetic patients.

The IHS and its stakeholders believe these investments will build the needed capacity in human capital for the future and be the most effective use of resources to address the growing AI/AN population.